STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010885	A. BUILDING: _____ B. WING _____	C 04/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00127835. Complaint IN00127835 - Substantiated, No deficiencies related to the allegations are cited. Survey Date: April 29, 2013 Facility Number: 010885 Provider Number: 010885 AIM Number: N/A Survey Team: Gloria J. Reisert, MSW, TC Census Bed Type: Residential 102 Total 102 Census Payor Type: Medicaid 32 Other 70 Total 102 Sample: 06 Riverbend was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00127835. Quality Review 04/30/13 by Lisa McColly	R 000		